

NEWS IN School Health

SCHOOL HEALTH UNIT

SPRING 1998

MANAGING ASTHMA: IN SUPPORT OF EDUCATION

Asthma is the most prevalent chronic disease among school-age children. Asthma often takes an enormous toll on many of our commonwealth's students and their families. This toll may be measured in absenteeism, lack of complete participation in academic, sports and social activities, and time taken from class for needed health services. However, with prevention and education, children can be assisted in controlling their asthma. This newsletter is designed to encourage a wide range of school personnel to proactively assist students to manage the condition and to participate fully in the educational experience. Our goal is to promote attendance, reassure parents that schools will respond effectively to their child's needs--and graduate the student with asthma, like all students, into healthy adulthood.

Many schools have taken a four-pronged approach to support children with asthma: (a) administration of medications in a timely fashion, (b) instruction on self management, (c) review of the environment to control triggers which may exacerbate the child's condition, and (d) coordination of care with local primary care providers.

Developing an individualized health care plan is essential for the child with asthma. Ideally, prior to school entry, the school nurse collaborates with the child's parents and provider to identify child-specific issues in the care plan. These include medications and peak-flow measurements, availability of inhalers, an emergency care plan and preparation of teachers and coaches about situations that may trigger the child's asthma.

A corollary to a child's developing independence is his learning to manage a chronic condition in a way that promotes self esteem and decreases interruption of daily activities. School nurses across the commonwealth are increasingly taking the lead in working with children, parents and providers to teach and/or reinforce methods of preventing the exacerbation of asthma. In some schools, this takes the form of individual counseling, while in others, groups of children with asthma learn together, often using one of the available age-appropriate curricula.

A review of the school environment is essential to recognizing triggers and possible ways to control them. Triggers vary widely, but most commonly include mold, animal dander, fumes, cigarette smoke and exercise (particularly when the child is exposed to cold air or seasonal pollens).

Key to any asthma management program is the coordination of care with the child's "medical home". Since Massachusetts has available health insurance for all children, the Department of Public Health is encouraging schools to identify the primary care provider and health insurer at entry. The school nurse and parents may then provide feedback to the provider about the child's response to the medical regimen. Asthma management offers an excellent opportunity for school and community professionals, insurers and parents to develop model asthma management programs, which promote both the child's health and his education.

Anne H. Sheetz, R.N., M.P.H., C.N.A.A.

Director of School Health

"Among children ages 5 to 17, asthma accounts for an annual loss of more than 10 million school days

per year.... With proper medical care and education, asthma symptoms can be controlled!"

- "Asthma Facts", Asthma and Allergy Foundation of America

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH BUREAU OF FAMILY AND COMMUNITY HEALTH

SCHOOL-AGE CHILDREN WITH ASTHMA

by Dorothy Page, FNP, MSN

University of Massachusetts Medical Center

Department of Pediatric Pulmonology, Worcester

Asthma is the most common chronic disease of childhood, affecting 4.8 million children yearly. The number of affected children is increasing each year. (CDC, Atlanta, Georgia, 1995). Children with asthma spent nearly 7.3 million days in bed, 10.1 million days missed from school and 1.9 million days in the hospital. (Taylor, William, "Impact of Childhood Asthma on Health", Pediatrics, Vol.90, #5, Nov. 1992).

Children with asthma pose a special concern in the school setting. This article is intended to be an overview of only some of the major concerns and issues for school nurses. I will highlight some of the questions that I frequently field from school nurses.

What causes asthma? Asthma is not a psychological illness. One cannot be "talked out" of an asthma episode. However, there are certainly children for whom a quiet and reassuring voice during an episode, will work wonders.

Asthma is a chronic lung disease. Simply stated, the asthma cycle is often hypersensitivity to an allergen (trigger) followed by an inflammatory response to that trigger resulting in bronchospasm, increased mucus production, air trapping and respiratory distress. The triggers for asthma in a child often include the very items we cannot avoid: viral illnesses, changes in weather, exposure to pollen and exercise. The school age child should not be encapsulated to avoid all potential triggers, but taught how to manage those exposures responsibly. For instance, if the child has exercise induced asthma, it is prudent to let the gym instructor know, let the child have the inhaler near-by during exercise and teach the child about warm-ups and pretreatment for potential problems. However, if the child is experiencing a recent serious flare-up of the asthma, then it may be wise to have the child choose a quieter activity for a few days. In other words, it's not very clear! The bottom line is that the child should be encouraged to participate in all school activities with whatever modification is necessary. It is not

appropriate for the majority of children with asthma to have a blanket excuse from activities for an entire year.

What are the medications? How often should they be given? When should the school nurse use them? Asthma medications in the school setting generally fall into two categories, based on the fact that asthma has two components. These are inflammation and bronchospasm. Thus, the medications are anti-inflammatories (Cromolyn, inhaled steroids, oral steroids, etc) and bronchodilators (Albuterol, Theophylline, etc).

The inhaled anti-inflammatory medications are generally used to prevent episodes. These are to be taken regularly on a daily or several times a day regimen. If an inhaled steroid is used, there are two considerations: it should be given with a spacing device (to minimize absorption from the mouth) and the child should rinse and spit after use

(for the same reason). These medications are not useful in the event of an asthma episode. The inhaled bronchodilator is the rescue medicine of choice.

The classification of bronchodilator is broad, but for purposes here, we are looking at the inhaled form of albuterol or similar bronchodilator. This medication may be used on a daily basis if the child has been having recent asthma breakthroughs. More frequently, it is used when the child is having trouble breathing. Any child who has a documented case of asthma should have a rescue bronchodilator available to him/her at all times. There are some children, particularly the younger ones, who do much better if the medication is administered via nebulizer instead of a metered dose inhaler (MDI).

TIP: The inhaler is empty if taken out of the plastic delivery case, placed in a glass of water and it floats.

What if the child comes to the school nurse's office and says he/she needs their medication: how does the school nurse know if the child really needs it? The school nurse should start with a quick once over assessment. How does the child look/facial color? Is he/she anxious? Are the accessory muscles being used to breathe? Is the child breathless: can he/she finish one-two sentences without gasping for air?

Based on the school nurse's "eyeball" assessment, it is often better to err on the side of extreme caution. If the school nurse's assessment is that this child is one of the most severe children she/he has seen, she/he should administer medication immediately, watching carefully for signs of increasing respiratory compromise. She/he should not hold off medication while phoning the parents or warming the stethoscope. A child that continues to worsen must be sent to the local pediatric emergency room via ambulance and parent(s) notified. Fortunately, that scenario happens less often, partly due to the vigilance of the school nurse and teachers.

The other child who may appear in the school nurse's office may be the child whom the school nurse suspects does not want to go to science class. Once again, she/he makes the same careful assessment as she/he does with any child. If the child does not seem to be in distress, the school nurse may have the child wait for a few minutes, and reevaluate. She/he should watch for a cough, wheezing, listlessness, etc. If the school nurse has the expertise in lung sounds, she/he can listen to the child's chest. Absence of wheezing does not mean the child is not having an asthma episode.

It may mean that the child cannot move enough air to wheeze! Wheezing is typically

heard in expiration as the child is trying to force air out of the overdistended lungs. Based on the school nurse's assessment, treat the child appropriately.

Some children may present to the nurse's office with a peak flow meter. This tool is only helpful if you know the parameters for that particular child. For instance, the product information may state that a child of X inches in height should blow Y amount. That is only a guideline.

One can be under or overtreated if the peak flow averages alone are used. The parent must be contacted to find out the treatment plan if the peak flow reading is the determination. For instance, if the peak flow is Y amount, the school nurse will administer Z medication. For the peak flow reading to be a good measure, the child must blow three times into the meter. All three measures must be within 20 points. The highest number is

the child's reading. For the child who wishes to get out of science class, the school nurse has a good use for the peak flow meter. No one can fake the readings three times in a row in a 20 point span!

What if the routine medications don't seem to keep the child in activities and classes? A contact with the parent is important. The parent should be encouraged to contact the physician or the school nurse may ask permission to do that herself/himself. Some parental medication forms include permission to call the doctor.

Should the child carry his/her medications? This depends upon several factors. There are school systems who have voted that no child should carry any medication on their person. The concern from the school's point of view is both overuse and sharing with another child. These are serious issues and need to be dealt with individually. The child should be able to demonstrate correct use of the inhaler to the school nurse. The school nurse must play a part in helping the administration to weigh the negative issues with the accessibility of the medication to the child when he/she needs it.

Although each of these issues may compromise a chapter of a textbook, this summarizes some of the key points in asthma care.

ASTHMA AND ADOLESCENTS

by Lydia A. Shrier, MD, MPH

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Instructor of Pediatrics, Harvard Medical School

Asthma is the most common chronic disease of youth. Teenagers are at highest risk due to lack of knowledge, inadequate or delayed access to health care, and developmental issues.

Asthma involves tightening and swelling of the airways in response to allergens (such as dust and animal dander), irritants (particularly smoke), respiratory infections, and exercise.

Asthma often appears to improve in adolescence as the airways grow larger and have more room to tighten and swell before causing obvious wheezing. However, exercise limitation, nighttime cough or shortness-of-breath, or frequent colds with wheezing may indicate that a teen has not "outgrown" asthma.

It is important to properly diagnose asthma, as people with symptoms more than twice a week may need daily preventative medication.

Adolescents may overuse their "quick relief" medication, usually albuterol, and mask worsening symptoms or experience decreased effectiveness of the medication. Albuterol does not treat airway swelling, which requires anti-inflammatory medication (steroids). These factors put adolescents at risk for death from asthma, but many adolescents feel that "it won't happen to me."

Teens with asthma must struggle with the potential stigma of a chronic disease. They may worry about appearing different or limited as they seek peer approval and acceptance. Many adolescents with asthma perceive themselves as "ill" or vulnerable, and therefore assume that they cannot participate in sports, including gym class (sometimes, this is seen as positive!). Even severely affected adolescents should be able to achieve good asthma control with appropriate management.

Adolescents need to feel respected and in control of their lives. Speaking directly with teens with asthma and giving them the knowledge necessary to understand the disease

is critical. They should be taught to recognize symptoms and triggers and self-monitor with a peak flow meter. Adolescents should learn to use medications appropriately and be able to independently access health care when needed. Adolescents with asthma are at risk for doing poorly physically, psychologically, and socially.

Providing them with education, respecting their need for autonomy, and identifying how asthma can affect their self-esteem and social interactions are essential to helping young people with asthma safely and healthily negotiate their teenage years.

THE ASTHMA DIARY

by Judi McAuliffe, RN, CSN

North Pembroke Elementary School, Pembroke

"*D*ear Diary: Today I had as good day." Almost everyone has written in a diary at least once, but

a not everyone has written in an *asthma diary*. Ask school nurse, "What is the most common diagnosis of a child who visits your health room?" The answer will be asthma. Students with asthma come to school with many symptoms in varying stages that can be characterized as intermittent, mild, moderate or severe. The treatments may be just as varied. An asthma diary is an invaluable tool for everyone involved in the child's care.

First the school nurse needs to communicate with the child's parents and obtain a health inventory, which includes specifics about the child's asthma, i.e., the triggers, symptoms, and treatments. Collaborating with the physician and parent, the school nurse may then establish a health care plan, which includes the medication orders. At the same time, the nurse should start an asthma diary by keeping a record of the student's peak flow readings, the symptoms, activities and precipitating factors. Asthma diary forms are available through such sources as the Asthma and Allergy Foundation and pharmaceutical companies. Some school nurses have designed their own forms.

A peak flow reading, like taking a child's temperature, provides, information needed to care for the child. Peak flow is the measurement of air flow limitation. It detects early stage airway obstruction and is information the primary care provider needs to manage the child's treatment plan. If a child does not already have a personal best peak flow, the nurse may have him/her do a minimum of one measurement daily for two weeks

(hopefully while symptom-free). Additional readings should be taken depending on the student's triggers. For example, if the child's asthma is exercise induced, the readings should be taken during recess or physical education activities. When recording the readings, the symptoms, as well as the corresponding activities, should be listed. The nurse should follow the physician's plan according to the peak flow zones (green, yellow, and red). If there is no zone plan, information about peak flow changes should be shared with the parent and/or physician.

Each time the student comes to the health room, the nurse has a teachable moment. What are the student's symptoms? Does the student know what triggered them? Could this have been avoided? Was a peak flow done? What does the reading mean? Is the inhaler being used properly? All of this

means that the student is moving toward self-management, less absenteeism and a happier and healthier educational experience--and being able to write: "Dear Diary: "Today I had a great day!"

Resources:

Asthma and Allergy Foundation, New England Chapter
220 Boylston St., Chestnut Hill, MA 02167
(617) 965-7771

Allergy & Asthma Network/Mothers of Asthmatics
3554 Chain Bridge Road, Suite 200
Fairfax, Virginia 22030-2709
1-800-878-4403

A PARENT'S EXPERIENCE

by Deb Berman

I immediately recognized the phone number on my pager. Two years ago, it would have sent tremors through my body. However, I calmly returned the call to the school nurse where my two children attend elementary school. My son, who is nine, has

asthma. The nurse was just letting me know that his breathing was great and that his peak flow was finally normal.

I'm one of those lucky parents. I have a very knowledgeable school nurse. I turned to her in my grief when my son was diagnosed with asthma. She told me the facts and what books to read (and even lent me a few). She informed me as to what to expect, what to watch for and what to inform her about. The communication between us is incredible. It has made the difference between my son always being absent and being watched and cared for while attending school. She monitors his peak flow, administers asthma medication and immediately informs me of any problems. Where another nurse would call me a "problem" mother, she welcomes my input.

It took the asthma physician, the school nurse and me a whole year to learn and get to know my child's asthma. Two years ago, my son's asthma raged out of control, forcing at least two hospital visits.

Proudly, my son has been without any hospital visits for the past year. I know for a fact that without

the help and support of the school nurse this could never have been possible.

"OPEN AIRWAYS"

Asthma Self Management Curriculum

by Mary Zamorski, RNC, FNP

Nursing Supervisor, Springfield Public Schools

*T*he American Lung Association sponsors an asthma management program called, "Open Airways in Schools". The goal of this program is to help children with asthma learn how to control their health condition, and, hence participate more fully in

the educational process.

For almost a year, the school nurses in Springfield have taught this program in grades kindergarten through eight. They have found it to be effective--and enjoyable--for teaching children in these grades, and they encourage parents to participate in the program.

To obtain the program, call the American Lung Association, either the local chapter or 1-800-292-5542. The association will send a package consisting of an instructor guide, curriculum, flip chart of posters, and a set of hand-outs. Staff of the American Lung Association have been available to help establish and support the program in our Springfield schools.

ASTHMA AND SPORTS:

PLAY SMART TO WIN!

by Michael Rich, MD, MPH

Attending Physician, Children's Hospital

Adolescent/Young Adult Clinic

Instructor, Harvard Medical School and

Harvard School of Public Health

Jackie Joyner-Kersey, the Olympic gold medalist in long jump and the seven-event heptathlon, once told me about her experience running track in high school. "I ran faster than anybody, the girls, the boys, and when I finished, I would keep running until I got behind the bleachers. I would hide there until I caught my breath, because I was afraid the coaches would think I was out of shape." In fact, she was suffering the effects of asthma which she did not know she had, asthma that would eventually cause her to collapse at the Pan American Games. Once she and her doctors diagnosed her asthma and treated it, Jackie went on to be one of the greatest American athletes ever.

This story tells it all. Asthma is to be taken seriously, but once it is, the playing field is level and a young person with asthma can compete and win as an equal. Asthma may declare itself in unexpected ways. Most people know about wheezing and shortness of breath, but an athlete with undiagnosed asthma may have chest pain or tightness, noisy

breathing, dry cough, or decreased

endurance. There does not need to have been to

a

have been a previous history of asthma. Often the increase in athletic activity as a teen brings out milder forms of asthma that were unnoticed before.

If a young person starts to feel tight or short of breath about 30 minutes after starting to exercise (even if they have already stopped), they may suffer from exercise induced bronchospasm, a related condition which does not have the long term chronic effects of asthma. Often the young person has had this response for some time, but has learned to limit his or her level of activity, even subconsciously, so that symptoms do not occur. If they stop and rest, the symptoms go away, but not immediately. Just as it takes a while for the airway response to cause symptoms, it takes time for it to resolve. This condition may or may not be associated with underlying chronic asthma – this is something for the young person to determine with his or her clinician. However, this condition is easily manageable. With appropriate treatment before exercise, the airway response never occurs and the young person can compete at full effort without concern.

Many asthma sufferers think that they cannot do gym class or sports because of their condition. With few exceptions, this is not true. If you are experiencing exercise limitations due to asthma, you are not disabled, you are undertreated. See your clinician. Likewise, if a student is holding back or appearing to be poorly conditioned, gym teachers and coaches should remain aware that asthma may be at work, not laziness or bad attitude. As supervisors of young peoples' most strenuous physical activity, they are in the front lines where symptoms will be noticed. If asthma can be detected and treated, they may discover they, too, have an Olympian that who thought that he or she was just out of shape.

INDOOR AIR QUALITY IN SCHOOLS

by Michael A. Feeney, R.Ph., J.D., C.H.O.

Massachusetts Department of Public Health

Bureau of Environmental Health Assessment

Indoor air quality (IAQ) in schools is an ongoing concern for students, parents, teachers, school departments, and municipal officials across Massachusetts. Conditions

such as malfunctioning ventilation systems, mold growth, or products

containing chemicals can each have a role in exacerbating pre-existing respiratory diseases, such as asthma.

In response to concerns about IAQ conditions in public buildings, the Department of Public Health (DPH), Bureau of Environmental Health Assessment (BEHA), Emergency Response/

Indoor Air Quality (ER/IAQ) Program conducts indoor air quality investigations upon request from the public, local boards of health or other municipal officials. The ER/IAQ Program uses the BEHA Indoor Air Quality Assessment Protocol to triage requests for assistance from the public. The Protocol provides a framework for referral to the proper government agency, dependent on the nature of the complaint.

When DPH is the appropriate agency to investigate an IAQ complaint, the local board of health is contacted to arrange a site visit to the school. Upon arriving at the school, an interview with school staff is conducted to gather information about the building and the extent of indoor air quality attributed problems. The ER/IA walk-through assessment may consist of an evaluation of the following conditions: the ventilation system; water damage to the building; school activities (e.g., use of pottery kilns); chemical storage; or other factors that can affect the indoor environment of a school.

For further information concerning indoor air quality assessments in schools, please contact Michael Feeney or Cory Holmes at (617) 624-5757.

ENVIRONMENTAL PROTECTION AGENCY'S

TOOLS TO BREATHE FREELY

by Mary Beth Smuts

Environmental Protection Agency

Spend a moment and think of your activities today; where were you? Most Americans adults spend 90% of their time in an enclosed space: home, work, commuting, and recreation. Our children spend at least 1/3 of their time inside their homes. Another 20% of their time is mandated to be spent in schools. That time spent inside may not be in a healthy environment. The indoor environment is

affected by human activities, by building material and furnishings and by outside sources entering the building.

The Environmental Protection Agency (EPA) has developed some checklists, manuals and recommendations in evaluating the home, office and schools for indoor environmental problems. The Indoor Air Quality (IAQ) Tools for Schools action kit, introduced in 1995, is now used proactively by schools across the nation. In Massachusetts, Chicopee, Walpole, Watertown and Carlisle are just a few of the school systems with indoor environmental teams using the action kit.

Those schools report numerous benefits from using the IAQ Tools for Schools approach. The most obvious one is a healthier school. If a school is comprehensively evaluating its indoor environment, such as its maintenance and operation of the ventilation system, its use of pesticides and chemicals, and its renovation and cleaning activities' schedules, then many common IAQ problems are prevented. Just following the simplest items on the checklists, such as whether there are animals in the classrooms, provides some help to asthmatic students by limiting some known asthmagens from the school. For more information on EPA's fact sheets and kits, please call the Indoor Air Quality Information Clearinghouse at 1-800-438-4318.

**THE FOOD ALLERGY--
ASTHMA CONNECTION
HOW MUCH DO YOU KNOW?**

by Julie Robarts

Massachusetts Department of Public Health

Scientific studies suggest that certain food allergies can sometimes trigger an asthma episode in people with asthma. Cover the answers at the bottom of this section, then take a few minutes to answer True or False to each question. Compare your answers to those provided here.

- 1) **T/F** Reactions to food allergies are minor compared to other allergies.
- 2) **T/F** In children with asthma, food allergies are a common trigger of asthma episodes.

- 3) **T/F** Food additives and artificial flavors cause the majority of food allergic reactions.
- 4) **T/F** Food additives such as benzoate, monosodium glutamate (MSG), and aspartame are known asthma triggers.
- 5) **T/F** Children will outgrow most food allergies.
- 6) **T/F** The symptoms of asthma episodes triggered by food allergies are exactly the same as those triggered by other allergens, such as mold, dust, pollen, or animal dander.
- 7) **T/F** Food allergies can not be cured.
- 8) **T/F** It is unlikely that a child will have a serious food allergy reaction at school, since most children with food allergies do not eat the school lunch.

ANSWERS:

- 1) **FALSE.** Food allergies can cause life-threatening anaphylaxis if the potential allergen is inadvertently ingested or inhaled, even in the smallest of amounts. As little as a 1/2 a peanut can cause a fatal reaction in severely allergic individuals. Each year more people die of food allergy reactions than from insect stings.
- 2) **FALSE.** Food triggered asthma is unusual. Of the 5 million children in the United States who have asthma, only 6-8% of them will experience episodes related to a food allergy. However, it is important to note that asthmatic children with food allergies are more likely to have a severe reaction than those who do not.
- 3) **FALSE.** Natural foods such as milk, eggs, peanuts, tree nuts, soy, wheat, fish, and shellfish constitute the eight main foods causing allergies. For children, milk is the most common cause of food allergies.
- 4) **FALSE.** Sulfites are the only food additives which have been linked to trigger asthma. Sulfites occur naturally in food but more commonly are added in processing as a preservative. Common food sources of sulfites include the following: dried fruits or vegetables, packaged/prepared potatoes, wine, beer, bottled lemon or lime juice, shrimp, and pickled foods.
- 5) **TRUE.** However, allergies to peanuts, nuts, fish and shellfish are usually life-long, and usually are the cause of the most severe allergic reactions.
- 6) **FALSE.** In addition to the more common asthma symptoms such as itching or tightness in the throat, difficulty breathing, or wheezing, symptoms to a food allergy can include vomiting, diarrhea, abdominal cramps, hives, swelling, eczema, and itching or swelling of the lips, tongue or mouth.

7) **TRUE**. There is no known cure for food allergies. Allergy shots, which can be useful in desensitizing people to pollen and other environmental allergens, are not recommended to treat food allergies and may be dangerous. The only way to avoid an allergic reaction from food is to avoid the known allergen.

8) **FALSE**. A study in the New England Journal of Medicine indicates that 4 of 6 fatal food allergy reactions in children occurred at school.

How can you help your students prevent food allergy reactions from triggering asthma episodes? As with any known trigger, avoidance of the allergen is important, but how do you help them do this?

- *Create an individualized asthma action plan for the student. This plan should include the following components :*

Be sure to ask the student about any food allergies when creating an individualized asthma action plan. If the food allergy is considered severe, encourage him/her to speak to a physician about carrying epinephrine and wearing a medical bracelet.

- *Have a plan in place for quick response and staff trained who can respond to severe reactions that may occur.*

Communicate regularly with the food service director and staff regarding food allergy reactions which occur in the cafeteria. Offer to help them create an effective system of alerting students, parents, and staff to new menu items that contain ingredients that are known allergens.

- *Educate students, staff, and parents about food allergies.*
- *For more information on asthma and food allergies, contact the following organizations:*

International Food Information Council

1100 Connecticut Avenue, N.W., Suite 430

Washington, DC 20036 <http://ificinfo.health.org>

The Food Allergy Network

10400 Eaton Place, Suite 700

Fairfax, VA 22030-2208

1-800-929-4040 <http://www.foodallergy.org>

American Academy of Allergy, Asthma and Immunology

611 East Wells Street, Milwaukee, WI 53202

1-800-822-2762 <http://www.aaaai.org>

A SAMPLE OF WEB SITES WITH ASTHMA INFORMATION

UNITED STATES:

Allergy and Asthma Network/Mothers of Asthmatics, Inc.: www.podi.com/health/aanma/

-- a non-profit membership organization with news/

information such as changes in metered-dose inhalers, and on-line surveys of asthma sufferers.

American Medical Association: [www.ama-assn.](http://www.ama-assn.org/special/asthma/asthma.htm)

[org/special/asthma/asthma.htm](http://www.ama-assn.org/special/asthma/asthma.htm)

American Academy of Allergy, Asthma and Immunology: www.aaaai.org -- includes public information materials (including "Childhood Asthma"), glossary of terms and lists of professional and lay organizations and a speaker's bureau.

American College of Allergy, Asthma and Immunology: allergy.mcg.edu -- hosts "Allergy, Asthma & Immunology Online" with information on the Nationwide Asthma Screening Program; the "Asthma Life Quality Test" and information such as EpiPen recalls.

American Lung Association: www.lungusa.org.

[org/homepage.html](http://www.lungusa.org/homepage.html) -- sections include "Learn about Lung Health: Asthma and Children".

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Children's Environmental Health Network:

www.cehn.org -- an extensive site of a California non-profit organization including information on a congressional briefing on asthma and respiratory diseases, as well as the proceedings from a conference heard in Feb. 1997 entitled "Children's Environmental Health: Research, Practice, Policy

& Prevention."

Centers for Disease Control: Agency for Toxic Substance and Disease Registry (ATSDR):

atsdr1.atsdr.cdc.gov:8080/child/index.html -- Kids Health Initiative 1998.

**National Allergy and Asthma Network/Mothers
of Asthmatics - 1-800-878-4403**

ColoradoHealthNet: www.coloradohealthnet.org.

[org/site/idx_asthma.html](http://www.coloradohealthnet.org/site/idx_asthma.html) or ([...org/asthma/](http://www.coloradohealthnet.org/asthma/)

[juvasthma_indexQnA.html](http://www.coloradohealthnet.org/asthma/asthma_indexQnA.html) for juvenile asthma specifically) -- a very extensive site with information on research, management, support programs, library and much more.

Dr. Doris Rapp's Web Site: www.drrapp.com -- includes lots of purchasable publications and videos, specifically "Environmentally Sick Schools".

Envirosense Consortium: www.envirosense.org -- membership organization of environmental companies with information on the Healthy School Environments '98 Tools for Schools, *"A Strategic Conference on Removing Environmental Hazards from our Nation's Schools"*.

National Education Association, Health Information Network, Air Quality:
www.nea.org/

hin/air/asthma.html -- "How Asthma-Friendly is Your School?" (see link to all major organizational sites at "Contact these organizations in this article").

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National Institutes of Health: National Heart, Lung & Blood Institute: www.nhlbi.nih.gov/nhlbi/

nhlbi.htm -- includes National Asthma Education and Prevention Program, Global Initiative for Asthma Publications for Patients and Health Professionals, including *Asthma and Physical Activity in the School; Your Asthma Can Be Controlled: Expect Nothing Less.*

National Institutes of Health: National Institute of Environmental Health Sciences: www.niehs.nih.gov

-- a large general resource on environmental health including a children's page with links to other health related sites for children: also ehis.niehs.nih.gov Environmental Health Information Service and ehpnet1.niehs.nih.gov/docs/1995 *Environmental Health Perspectives* Vol. 103 suppl 6. Sept. 1995: (journal) article. Preventing Child Exposures to Environmental Hazards: Research & Policy Issues.

Disclaimer: All sites are listed for information and educational purposes only. The Massachusetts Department of Public Health does not endorse or recommend any web site or its contents.

ASTHMA RESOURCES

Publications, Materials, Videos

Asthma and Allergy Foundation of America - 1-800-727-8462

- Managing Asthma: A Guide for Schools #2650
- Asthma Awareness Curriculum for the Elementary Classroom #2894
- Making a Difference...Asthma Management in the School (videotape) #55-643
- Asthma Care Training for Kids (ACT)
- You Can Control Asthma (Low-literacy education books, ages 6-12)

- Student Asthma Action Card

This organization publishes a newsletter on asthma for allied health personnel, "Exchange". Call for a free copy.

American Academy of Allergy Asthma & Immunology - 1-800-822-2762

Managing Allergies and Asthma at School: Tips for School Teachers and Staff

American Lung Association (local chapter) or 1-800-292-5542

- Open Airways for Schools (Elementary school curriculum)

National Heart, Lung, and Blood Institute - (301) 251-1222

- Educational Materials Catalog

ADDITIONAL CONTACTS

Asthma & Allergy Foundation of America New England Chapter - (617) 965-7771

National Asthma Education and Prevention Program Information Center - (301) 251-1222

The Food Allergy Network - 1-800-929-4040

National Institute of Allergy and Infectious Diseases - (301) 496-5717

SCHOOL BASED HEALTH CENTERS

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Meetings

The Spring meeting of the School-Based Health Centers (SBHCs) is scheduled for Thursday, May 21, 1998. The day long meeting is held at the Keefe Technical High

School in Framingham. If you would like more information, call Anne DeMatteis at (617) 624-5473.

The fourth annual meeting of the National Assembly on School-Based Care (NASBHC) will be held in Los Angeles June 25-27, 1998. The title of this year's conference is "Communities Creating Access to Care." For more information, call NASBHC at 888-286-8727.

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The **Massachusetts Coalition of SBHCs**, with funding from the McKesson Foundation, recently hired Ruth Soderberg, a Nurse Practitioner and previously the Director of the SBHC program at Taunton High School, as their new Coordinator. The Coalition office is housed at The Medical Foundation at 95 Berkeley Street, Boston 02116.

The Coalition has many projects planned, including work to: enhance the visibility of the Centers; explore funding opportunities and resource partnerships; identify evaluation projects that further demonstrate the value of SBHCs; and develop and coordinate a resource library of materials for Coalition members.

Development of New School-Based Health Centers - As a result of last year's Community Health Network Areas, Request for Response process, the Department funded nine "Planning" grants to allow agencies to initiate or continue the planning and early implementation of new sites. Additional sites are being planned in Boston, Lawrence, Lowell, Taunton, Middleborough, Worcester, and two rural sites in regional schools in Huntington and Shelburne Falls.

Information About Starting School-Based Health Centers - Any school or agency that wants to investigate the feasibility of opening a School-Based Health Center in their community should contact the Department for available materials on SBHCs. Call Anne DeMatteis at (617) 624-5473.

You are also directed to take a look at the World Wide Website for "Making the Grade" at <http://www.gwu.edu/~mtg>.

MASSACHUSETTS ROLLS OUT

NEW STATE-WIDE MUNICIPAL MEDICAID INITIATIVE

(that will bring new federal dollars to cities and towns)

by John Seaver

Director of the Municipal Medicaid Program

Over the past several months, the Municipal Medicaid program has been launching a new state-wide initiative that will bring millions of new federal dollars to Massachusetts cities and towns who enroll their local schools as Medicaid administrators. Currently, through the special education programs, the Municipal Medicaid program returns about 40 million dollars annually to cities and towns across the state. John Seaver, Director of the Municipal Medicaid Program, has been meeting with mayors, school superintendents, and school health personnel throughout the state in an effort to inform municipalities about this expanded initiative. To date, more than 200 Massachusetts cities and towns have enrolled their schools as Medicaid Administrators.

Schools that enroll as Medicaid Administrators will provide Medicaid outreach activities, assist students with Medicaid eligibility, and coordinate, plan and monitor the health care needs of their students. School nurses, physicians, physical, occupational, and speech therapists, psychologists, social workers, school adjustment counselors, case managers, as well as vision and hearing specialists, are considered part of this program.

In order to determine the amount of reimbursement, the school district must conduct periodic time studies for each staff member included in Municipal Medicaid. Questions about the time study, or the "bubble sheets" being used, should be directed to Debbie Foster at (617) 451-7167.

In order to promote coordination of care with primary care providers, Medicaid has sent a list of all children on MassHealth (for each school district) to the Medicaid Coordinator of that school district. School nurses should contact the Medicaid Coordinator in their school districts for a copy of the list.

Representatives from cities and towns are encouraged to contact John Seaver at (617) 210-5687 to learn more about this initiative.



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MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

BUREAU OF FAMILY AND COMMUNITY HEALTH

DIVISION OF PREVENTION

SCHOOL HEALTH UNIT

250 WASHINGTON STREET, 4TH FLOOR

BOSTON, MA 02108-4619

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Janet Burke, Administrative Secretary, (617) 624-5471

Tom Comerford, School Health Administrator, (617) 624-5472

Anne DeMatteis, School-Based Health Center Program, (617) 624-5473

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Carlotta Hampton, Program Coordinator, (617) 624-5494

Alice Morrison, School Health Advisor, (617) 624-5476

Caty Sibble, Program Coordinator, (617) 624-5474